'ARTMENT OF HEALTH AND HUMAN SERVICES
ITERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/02/2008
FORM APPROVED
OMB NO. 0938-0391

MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G169	A. BUILDING _____ B. WING _____	03/13/2008

OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RO HOMES	8020 EASTERN AVENUE, NW WASHINGTON, DC 20012

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000	INITIAL COMMENTS A recertification survey was conducted from March 10, 2008 through March 13, 2008. The survey was initiated using the fundamental survey process. Due to deficient practices, however, the survey was extended on March 12, 2008 to examine the condition of Active Treatment. A random sample of three clients was selected from a resident population of two men and three women with various disabilities. The findings of the survey were based on observations, interviews with clients and staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports.	W 000		
104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interviews with direct support and administrative staff, and the review of records, including incident reports, the governing body exercised general policy and operational direction over the facility, except in the following areas. The findings include: 1. Cross-refer to W153. The governing body failed to ensure that facility staff followed policies and procedures for notifying appropriate personnel of client injuries. 2. Cross-refer to W159, W214, W249 and W436. The governing body failed to establish and	W 104	W 104 The Agency has a Policy on Incident Reporting and Management. A copy has been forwarded to the Day Program along with a list of Emergency Contact numbers. The QMRP and nurse will continue to visit the day program at least on a monthly basis to ensure continuous delivery of services is provided. Monthly QA audits will be completed and filed. See attached receipt from Day Program for the Incident Management Policy, Monthly QA audit and Emergency contact numbers	4/10/08

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DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2008 APR 11 P 1:47

TORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Sloan RN, BSN, MA | TITLE: VP - Operations | (X6) DATE: 4/10/08

iency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that eguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 owing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued participation.

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104	Continued From page 1 implement sufficient internal quality assurance measures to ensure the delivery of continuous active treatment services.	W 104		
120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure that outside services met the needs for one of three clients include in the sample. (Client #3) The finding includes: The facility failed to ensure that Client #1's day program had a system to effectively communicate client's medical/nursing needs. Client #1's day program records contained two "Inter-Agency Communication" (IAC) forms, dated October 22, 2007 and October 23, 2007, indicated body temperatures of 101 degrees and 100.1 degrees, respectively. Review of the facility's records failed to evidence (nursing notes or IAC form) that the nurse was aware of the client's elevated temperature on October 22, 2007. The client returned to the day program on the next day (October 23, 2007) without verification from the group home that the client was assessed by the facility's medical/nursing staff. Later that day, at 3:30 PM, the client was reassesed by the day program and diagnosed with an elevated temperate of 101 degrees.	W 120	W 120 The Agency has a Policy on Incident Management and Reporting. The Day Program has been given a copy of the same and the staff at the day program has been in serviced on this policy and procedure. A daily communication book has been initiated and day program and residential staff is aware to look for any documentation. The day program has received a list of Emergency Contact numbers. See attached – Incident Management Policy. Staff in-service record from day program. Emergency contact list.	4/8/08
136	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS	W 136		

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W 136	Continued From page 2 The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that clients participated in community outings/ recreational activities in accordance with their Activity Schedules, for two of the three clients in the sample. (Clients #1 and #2) The findings include: 1. On March 12, 2008, at approximately 10:28 AM, review of Client #1's Individual Support Plan (ISP), dated September 6, 2007, revealed a list of preferred activities which included "go on outings... going to church." At 12:02 PM, review of Client #1's Activity Schedule that was incorporated in his ISP, revealed that on Saturdays, he was to go out in the community, beginning at 11:00 AM. On Sundays, the client was scheduled to attend church at 10:00 AM and engage in another community activity, beginning at 3:00 PM. On March 13, 2008, beginning at 10:27 AM, review of Client #1's Community Outings documentation chart for the period October 2007 to date revealed the following: There was no evidence that he went to church in October 2007, November 2007, February 2008 or thus far in March 2008; The October 2007 outings sheet reflected one Thursday evening outing (nightclub, October 4,	W 136	W 136 The facility will ensure that each individual will participate in community outings in accordance with their ISP activity schedule. The QMRP will complete a monthly QA of the ISP record and have weekly oversight to ensure the individuals have the opportunity to participate in social, religious and community outings. The staff has been in serviced on accurate documentation of all outings in the clients' recreation log and active treatment. See attached staff in service record and activity record.	4/12/08

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W 136	Continued From page 3 2007) and one Sunday trip to a shopping mall (October 7, 2007); There were two outings documented in January 2008: church on Tuesday, January 8, 2008 and a "national monument" on Saturday, January 12, 2008; The three outings documented in February 2008 were on weekday evenings; none were on weekends; and, There were no documented outings thus far in March 2008. 2. On March 13, 2008, at 12:01 PM review of Client #2's Activity Schedule that was incorporated in her January 4, 2008 annual ISP, revealed that on Saturdays, she was to go out in the community, between 2:00 PM - 5:00 PM. On Sundays, the client was scheduled to attend church at 10:00 AM and later, engage in another community activity, from 2:00 PM - 5:00 PM. A subsequent review of Client #2's Community Outings documentation chart for the period January 1, 2008 to date revealed no evidence that she went on community outings on Saturdays and Sundays, in accordance with her plan.	W 136		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview, review of incident reports and	W 153		

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153	Continued From page 4 review of client records, the facility failed to ensure that all injuries of unknown origin were consistently reported immediately to the administrator. The findings include: On March 10, 2008, beginning at 8:30 AM, the recently-assigned Qualified Mental Retardation Professional (QMRP, January 15, 2008) and recently-assigned LPN Coordinator (February 10, 2008) were interviewed for the Entrance Conference. To their knowledge, the only incident involving Client #1 was when he developed a high body temperature in October 2007. On March 11, 2008, however, review of the client's record at his day program revealed the following: 1. According to a day program September 2007 Monthly Nursing Progress Note, Client #1 "was brought by staff to the infirmary with a nose bleed" on September 6, 2007. The note indicated that the "bleeding stopped spontaneously." The nurse further documented having taken his vital signs and applied an ice pack. No cause of bleeding was indicated. A corresponding "Inter-Agency Communication" form (sent to the home) indicated the day program nurse had assessed him at 2:00 PM. On March 11, 2008, at 10:12 AM, review of Client #1's residential Nursing Progress Note revealed no entries for September 6, 2007. An LPN did, however, write the following on September 7, 2007: "No nose bleeding at this time. Day program nose bleeding occurred..." There was no evidence that staff at the day program or at home completed an incident report and no evidence that the administrator was informed of this injury of	W 153	W 153 The incident was reported and an inter agency communication report was received from the day program but this was not passed on to the residential managers. The QMRP, House Manager and Nurse are not currently employed at the facility. In the future the QMRP and nurse will make sure there is open lines of communication between the day programs and facility. The day program and residential staff have been in serviced on communication, communication book, emergency contact #s.	4/8/08

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W 153	Continued From page 5 unknown origin. During the Exit meeting on March 13, 2008, it was acknowledged that the cause of the nose bleed had never been investigated or otherwise established. 2. The client's day program January 2008 Monthly Nursing Progress Note included the following: "On 1/29/08 staff noticed a scratch about 3 1/2 cm long. No bleeding noted. Area cleaned... no apparent distress noted. Nursing consult was sent home." There was no corresponding incident report and no evidence that the administrator had been informed of this injury of unknown origin. On March 11, 2008, at 1:43 PM, review of Client #1's residential Nursing Progress Note revealed no entries for January 29, 2008 and no indications of scratches noted in the days immediately preceeding, or afterwards. At 4:49 PM, the QMRP and LPN Coordinator both stated that they were previously unaware of any scratches observed on Client #1. [Note: The current House Manager began working in this facility in late February, approximately 2 weeks before the survey.]	W 153		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to integrate, coordinate and monitor active treatment programs, for three of the three clients in the sample. (Clients #1, #2 and #3)	W 159		

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W 159	Continued From page 6 The findings include: 1. The QMRP failed to ensure that Client #1's mealtime protocol and self-feeding training program were implemented correctly, as follows: Cross-refer to W249.1. Observations at breakfast and dinner on March 10, 2008, revealed that staff provided Client #1 with hand over hand assistance while loading food onto his spoon as well as raising the spoon to the client's mouth. On March 12, 2008, review of the client's OT assessment, dated September 25, 2008, revealed that he needed staff assistance to load food onto his spoon; however, he was capable of bringing the spoon to his mouth with minimal assistance. On March 13, 2008, at approximately 3:05 PM, review of Client #1's mealtime protocol, dated November 10, 2007, revealed the following: "<client's name> can bring the spoon from the plate to his mouth and remove food from the spoon but he does not initiate loading spoon with food." Observations on March 10, 2008, however, had shown that staff did not allow or encourage him to perform those tasks to his maximum abilities. Instead, they provided hand over hand assistance throughout the process, and documented on the data collection sheet that this was the level required. 2. The QMRP failed to develop and implement a privacy skills training program after Client #1's team recommended one on August 31, 2007, as follows: During the March 10, 2008 Entrance Conference, it was stated that Client #1 used adult protective undergarments due to fecal and urinary	W 159		

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159	Continued From page 7 incontinence. On March 12, 2008, at 11:40 AM, review of his IPP, dated August 31, 2007, revealed the following: "...will open and close the restroom door and display appropriate restroom behaviors daily 25% of the total opportunities provided for 3 consecutive months..." This was not observed being implemented when the client used the restroom during the survey. Beginning at approximately 12:25 PM, review of the client's program book revealed no evidence that data collection sheets had been established for this program. There was no actual program written, and no instructions for implementing the program. Further review revealed that QMRP Monthly Progress Notes, dated 9/7/07, 10/6/07, 11/7/07, 12/8/07, 1/4/08 and 2/7/08, failed to report on the status of this training objective. 3. The QMRP failed to ensure that staff consistently implemented Client #1's napkin-use training program, as follows: Cross-refer to W249.3. On March 10, 2008, Client #1 was observed at breakfast, snack and dinner. At each meal, staff were observed using a napkin to wipe his mouth periodically during the meal and after he finished eating. At no time were staff observed offering the client his napkin, with instructions and/or encouragement to wipe his own mouth. On March 12, 2008, at 11:26 AM, review of his IPP, dated August 31, 2007, revealed the following: ".Given physical assistance, <client's name> will use a napkin to wipe his mouth after meals on 80% of trials for 6 consecutive months..." Review of the QMRP Monthly Progress Notes, dated 9/7/07, 10/6/07, 11/7/07, 12/8/07, 1/4/08 and 2/7/08, revealed that staff had been recording the client's napkin use. Observations on March 10, 2008, however, failed	W 159		

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159	Continued From page 8 to show evidence that the program was being implemented consistently. 4. The QMRP failed to ensure that Clients #1 and #2 participated in community outings/ recreational activities in accordance with his/ her Activity Schedules, as follows: Cross-refer to W136. On March 12, 2008, at 12:02 PM, review of Client #1's Activity Schedule that was incorporated in his September 7, 2007 annual plan, revealed that on Saturdays, he was to go out in the community, beginning at 11:00 AM. On Sundays, the client was scheduled to attend church at 10:00 AM and engage in another community activity, beginning at 3:00 PM. On March 13, 2008, at 12:01 PM, review of Client #2's Activity Schedule revealed a similar schedule. On March 13, 2008, review of Client #1's Community Outings documentation chart for the period October 2007 to date revealed the following: There was no evidence that he went to church in October 2007, November 2007, February 2008 or thus far in March 2008; The October 2007 outings sheet reflected one Thursday evening outing (nightclub, October 4, 2007) and one Sunday trip to a shopping mall (October 7, 2007); There were two outings documented in January 2008: church on Tuesday, January 8, 2008 and a "national monument" on Saturday, January 12, 2008; The three outings documented in February 2008 were on weekday evenings; none were on weekends; and, there were no documented outings thus far in March 2008.	W 159		

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W 159	Continued From page 9 Review of Client #2's Community Outings documentation chart for the period January 1, 2008 to date revealed a similar dearth of community outings on Saturdays and Sundays. 5. The QMRP failed to ensure that Clients #1 and #2 had available for use the adaptive equipment prescribed for mealtimes, as follows: Cross-refer to W436. Client #1's mealtime protocol, dated November 11, 2007, and annual plan indicated the use of a "tumbler cup with straw lid." Client #2's mealtime protocol, dated December 14, 2007, and annual plan indicated the use of a Teflon-coated spoon. Neither client, however, was observed using those items during breakfast, afternoon break or dinner observations on March 10, 2008 6. The QMRP failed to ensure that the day program received standing physician's orders and accurate contact information as evidenced below: a) Client #1's day program records contained two "Inter-Agency Communication" (IAC) forms, dated October 22, 2007 and October 23, 2007, indicated body temperatures of 101 degrees and 100.1 degrees, respectively. The client's chart reviewed in the group home included standing PRN physician's orders (POs) for:"Acetaminophen 325 mg tab, 2 tabs (650 mg) by mouth twice daily as needed for temperature greater than 100." There was no evidence, however, that the day program nurse had administered medication on either October 22 or 23, 2007. On March 10, 2008, at 1:51 PM, the day program case manager was asked to verify that Client #1 had not received medication to lower his temperature. She consulted with their	W 159	W 159 1. Staff has been in serviced on the client's mealtime protocol. 2. The client's privacy program has been discontinued as the IDT felt he was incapable of comprehending 'privacy' considering his cognitive functioning level is 9 mths. And his adaptive functioning level is 1yr 9mths. 3. The client's 'napkin' program has been discontinued as the IDT felt he was incapable of wiping his mouth during meals due to his level of cognitive and adaptive functioning. 4. The QMRP and House Manager will ensure that the recreation calendar is followed and the clients have the opportunity to go out. The staff has been re in serviced in accurate documentation of all outings. 5. The clients are currently using the appropriate adaptive equipment – a straw lid cup and plastic coated spoon has been sent to the day program also. 6. a.- The Agency Policy and Procedure for Medication Administration, the POS and the PRN medications have been given to the day program and the day program staff has been in serviced. b.- The facility has given the day program a contact list of all emergency phone numbers.	4/10/08

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159	Continued From page 10 nurse and replied:"No, not unless we have a physician's orders... that would be the home." b) The "Inter-Agency Communication" (IAC) forms dated October 23, 2007 had included: "unable to reach you at 202-4XX-0467." Interview with the RN on March 10, 2008 revealed that he number cited on the document was incorrect by one digit. There was no evidence, however, that the QMRP had followed-up with the day program at that time to ensure that they had correct contact information for reaching the facility's nursing staff in the event of medical emergencies. 7. The QMRP failed to ensure that nursing staff consistently implemented Client #3's self-medication training program, as follows: Cross-refer to W249.6. On March 10, 2008, at 4:52 PM, the nurse punched Client #3's medication (Zyprexa) from its blister pack into a small medication cup. The client brought her glass of water from the kitchen and when the nurse handed her the medication cup, she took the medication independently, followed by water. On March 11, 2008, at 2:06 PM, review of the client's medical records revealed that the client had a 7-task self-medication objective whereby she was to obtain a key to a medication box, open the box, read the medication label, obtain the medication, place the medication in the box, obtain her own water and then swallow the pills under supervision. Subsequent review of the program data collection sheet revealed that the nurse had recorded Client #3 having obtained the key, opened the box and obtained the medication with verbal prompts on the previous evening (March 10, 2008), even though the client had not been observed performing those tasks.	W 159	7. The client's self medication program has been changed. 8. The psychologist has re assessed client#1 and see the attached psychological addendum to include the shirt mouthing and toileting behaviors. In the future the QMRP will ensure that there is implementation of all programs. The QMRP will complete a monthly QA.	4/10/08

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159	Continued From page 11 8. The QMRP failed to ensure that Client #1 received a comprehensive assessment , to include his behavior of mouthing/ chewing on his shirt sleeves and collar, as well as an update on his toileting skills, as follows: Cross-refer to W214. Observations throughout the day on March 10, 2008, in the home and at day program, revealed Client #1 routinely put his shirt sleeves and/or shirt collar into his mouth. Interviews revealed that this was not among the behaviors targeted in his Behavior Support Plan (BSP). On March 11, 2008, at 5:25 PM, the Qualified Mental Retardation Professional stated that the psychologist was scheduled to come to the facility,the next week to assess the client's shirt-mouthing behavior and to provide appropriate recommendations. The QMRP also stated that Client #1 was not on a set toileting schedule and that staff relied solely on the use of adult protective undergarments. The previous QMRP had reported that the client had reached his "highest level of performance" with a previous training objective and recommended discontinuing the program. Further interview and record review revealed no evidence that the client's toileting skills had been re-assessed to determine the next appropriate intervention strategy for the interdisciplinary team to consider. On March 12, 2008, beginning at 9:20 AM, review of Client #1's Psychological Assessment, dated August 30, 2007, revealed no evidence that the psychologist had assessed this shirt-mouthing behavior previously or re-assessed his toileting skills and training needs.	W 159	See attached Mealtime protocol Client rights/privacy Activity schedule Receipt from day program Self medication program In service sheets Psychology assessment Adaptive Equipment Active treatment	4/10/08
214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must	W 214		

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214	Continued From page 12 identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each client had a comprehensive assessment on file that depicted his/her current functional status, for one of the three clients in the sample. (Client #1) The finding includes: 1. The facility failed to assess Client #1's shirt-mouthing behavior. On March 10, 2008, Client #1 was observed in the home between 7:06 AM - 7:33 AM. His shirt collar was notably wet throughout the period. On several occasions, the client placed his shirt collar in his mouth and held it there for several minutes. At 7:33 AM, the House Manager assisted him with changing into a different shirt, before leaving for day program. Client #1 was observed in his day program between 12:27 PM - 12:50 PM. The ends of both shirt sleeves and his collar were wet upon this surveyor's arrival. The client repeatedly put his shirt sleeves into his mouth. Day program staff confirmed that the client routinely placed his shirt in his mouth. At 12:38 PM, the staff rolled the client's shirt sleeves up and commenced to play ball toss. At least three times between 12:38 PM - 12:48 PM, the client rolled the sleeves back down and staff asked him to keep them sleeves rolled up. He kept his left thumb buried inside his left shirt sleeve, and mouthed it occasionally. At 12:31 PM, another staff person assisted the client	W 214	W 214 1. Client#1 has been assessed by the psychologist for his shirt mouthing and toileting behaviors 2. This program has been discontinued, as the client is unable to comprehend his toileting needs. He is functioning at a 9mth cognitive level and a 1yr 9mth adaptive level. Staff continue to follow a 2hr APU check. I n the future the QMRP will work closely with consultants to ensure all of the client's on going behaviors and needs are addressed. The QMRP completes a monthly QA and monthly notes on each client.	4/10/08

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214	Continued From page 13 with changing into a fresh shirt (red) and pants. The staff who had engaged him in ball toss stated that even though he did it daily, mouthing his clothes was not among the behaviors targeted in his Behavior Support Plan (BSP). Evening observations of Client #1 resumed upon his return home. At 4:28 PM, Client #1 was seated at the dining room table eating snack. The collar and both sleeves of the red shirt (worn since the change at day program) were notably wet. At 5:58 PM, Client #1 was observed mouthing his shirt collar. He remained in the wet shirt until at least 6:41 PM (possibly longer). On March 11, 2008, at 5:25 PM, the Qualified Mental Retardation Professional stated that the psychologist was scheduled to come to the facility the next week to assess the client's shirt-mouthing behavior and to provide appropriate recommendations. On March 12, 2008, beginning at 9:20 AM, review of Client #1's Psychological Assessment, dated August 30, 2007, revealed the following: "...also suck his fingers, engage in hand to mouth self-stimulation behaviors, bite finger nails sometimes..." There was no evidence, however, that the psychologist had assessed his behavior of sucking on shirt sleeves and/or collar. 2. The facility failed to re-assess Client #1's toileting skills: During the March 10, 2008 Entrance Conference, it was stated that Client #1 used adult protective undergarments (APUs) due to fecal and urinary incontinence. On March 12, 2008, at 9:32 AM, review of the client's Annual Psychological Assessment, dated August 30, 2007, revealed the	W 214		

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W 214	Continued From page 14 following: "... is not toilet trained but he will sometimes urinate and defecate in toilet when assisted." The psychologist provided no further information or recommendations regarding toileting skills. Review of Client #1's September 7, 2007 Individual Support Plan (ISP), at 10:16 AM, revealed the following: "... uses adult attends continues to be on a program to improve his toileting skills." At 11:40 AM, however, review of his IPP, dated August 31, 2007, revealed no training objective that dealt directly with his toileting needs. On March 12, 2008, at approximately 12:18 PM, the recently-hired QMRP was asked about Client #1's toileting program. He reported that Client #1 was without a set toileting schedule. Staff relied on the use of APUs because the client often refused to use the toilet. The interview revealed that there were behavioral considerations that to date, had not been fully assessed. According to the QMRP, the client generally would agree to sit on the toilet if staff loosened his belt, made a request and then stepped back. However, if staff removed the belt and lowered his pants for him, the client would resist. If staff continued to insist, then he would refuse to cooperate. While there was no toileting schedule prescribed, staff reportedly checked his APU upon return from day program and periodically thereafter, and changed him if/when wet. QMRP Monthly Progress Notes, dated 9/7/07, 10/6/07, 11/7/07, 12/8/07, 1/4/08 and 2/7/08, had reported on the following goal: "Three times weekly with staff assistance, <client's name> will complete the steps to proper toilet use with 80% accuracy..." Further review revealed that the QMRP had written the following statement in	W 214		

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/ 214	Continued From page 15 each monthly report, beginning at least as far back as February 6, 2007: "He performed Step 1 with verbal prompt, Steps 2-7 with physical prompts. He has reach his highest level of performance. Program discontinued and continue on an informal basis." While Client #1's September 7, 2007 ISP indicated that he"... uses adult attends continues to be on a program to improve his toileting skills," there was no evidence that the interdisciplinary team had reviewed the client's progress or lack thereof, discussed the former QMRP's recommendation (since February 2007) to discontinue the formal training program, and agreed that a toileting schedule would not be appropriate for Client #1.	W 214		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure continuous active treatment and/or implement programs as outlined in the Individual Program Plans (IPPs), for three of the three clients in the sample. (Clients #1, #2, and #3) The findings include:	W 249		

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249	Continued From page 16 1. Client #1's mealtime protocol and self-feeding training program were not implemented as written, as follows: On March 10, 2008, beginning at approximately 7:10 AM, a direct support staff person was observed providing Client #1 with hand over hand assistance while eating breakfast. Together, they loaded food onto the spoon and together, they raised the spoon to the client's mouth. At approximately 4:30 PM that evening, direct support staff was observed providing the same level of hand over hand assistance while eating a snack (pudding). And beginning at 6:02 PM, the recently-hired (2 weeks) House Manager was observed providing the same level of hand over hand assistance with the dinner meal. a. On March 11, 2008, at 10:23 AM, review of the client's annual plan, dated September 7, 2007, revealed that the client "requires partial hand over hand assistance with feeding." On March 12, 2008, at 12:25 PM, review of his IPP revealed the following: "With independence, <client's name> will use a spoon to feed himself during breakfast and dinner on 50 % of trials..." Although the training objective did not provide clear instructions to staff on how to implement the program, review of the client's OT assessment, dated September 25, 2008, revealed that he needed staff assistance to load food onto his spoon; however, he was capable of bringing the spoon to his mouth with minimal assistance. On March 13, 2008, at approximately 3:05 PM, review of Client #1's mealtime protocol, dated November 10, 2007, revealed the following: "<client's name> can bring the spoon from the plate to his mouth and remove food from the spoon but he does not	W 249	W 249 1a and b. cross refer to W 159 2. cross refer to W 159-1 3. cross refer to W 159-2 4. cross refer to W 159-7 5. cross refer to W 159-5	

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W 249	Continued From page 17 initiate loading spoon with food." Observations on March 10, 2008, however, had shown that staff did not allow or encourage him to perform those tasks to his maximum abilities. Instead, they provided hand over hand assistance throughout the process, and documented on the data collection sheet that this was the level required. b. On March 10, 2008, at 4:45 PM, the medication nurse crushed Client #1's medications and stirred them into apple sauce. At 4:56 PM, the nurse spoonfed the mixture into the client's mouth, without offering him the opportunity or encouragement to hold the spoon himself. At 5:30 PM, during a post-med pass conversation, the LPN indicated that she was aware that the client received hand over hand assistance while eating food. After stating that the training program was to be implemented at meals, she acknowledged that she did not routinely provide the client with an opportunity to practice using a spoon during his med pass. 2. The facility failed to implement Client #1's privacy skills training program, as follows: During the March 10, 2008 Entrance Conference, it was stated that Client #1 used adult protective undergarments (APUs) due to fecal and urinary incontinence. On March 12, 2008, at 11:40 AM, review of the client's IPP, dated August 31, 2007, revealed the following: "...will open and close the restroom door and display appropriate restroom behaviors daily 25% of the total opportunities provided for 3 consecutive months..." This was not observed being implemented when the client used the restroom during the survey. On March 12, 2008, beginning at approximately 12:25 PM, review of the client's program book revealed no	W 249		

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V 249	Continued From page 18 evidence that data collection sheets had been established for the "open/ close the bathroom door" program. 3. Facility staff failed to consistently implement Client #1's napkin-use training program, as follows: On March 10, 2008, beginning at approximately 7:10 AM, Client #1 was observed at breakfast. Later, at approximately 4:30 PM, he ate a snack (pudding). The client was also observed at dinner that day, beginning at 6:02 PM. Direct support staff and/or the recently-hired House Manager provided direct assistance to Client #1 throughout the meals. Each time, staff was observed using a napkin to wipe his mouth periodically during the meal and after he finished eating. At no time were staff observed offering the client his napkin, with instructions and/or encouragement to wipe his own mouth. On March 12, 2008, at 11:26 AM, review of his IPP, dated August 31, 2007, revealed the following: ".Given physical assistance, <client's name> will use a napkin to wipe his mouth after meals on 80% of trials for 6 consecutive months..." Review of the QMRP Monthly Progress Notes, dated 9/7/07, 10/6/07, 11/7/07, 12/8/07, 1/4/08 and 2/7/08, revealed that staff had been recording the client's napkin use. Observations on March 10, 2008, however, failed to show evidence that the program was being implemented consistently. 4. The facility nurse failed to implement Client #3's self-medication training program, as follows: During the medication pass observation on March	W 249		

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249	Continued From page 19 10, 2008, at 4:52 PM, the nurse punched Client #3's medication (Zyprexa) from its blister pack into a small medication cup. The client brought her glass of water from the kitchen and when the nurse handed her the medication cup, she took the medication independently, followed by water. On March 11, 2008, at 2:06 PM, review of the client's medical records revealed that the client had a 7-task self-medication objective whereby she was to obtain a key to a medication box, open the box, read the medication label, obtain the medication, place the medication in the box, obtain her own water and then swallow the pills under supervision. It should be noted that the nurse documented on the data collection sheet that Client #3 had obtained the key, opened the box and obtained the medication with verbal prompts on the previous evening (March 10, 2008), even though the client had not been observed performing those tasks. 5. The facility failed to ensure that Clients #1 and #2 had available for use the adaptive equipment prescribed for mealtimes, as follows: Cross-refer to W436. Client #1's mealtime protocol, dated November 11, 2007, and annual plan indicated the use of a "tumbler cup with straw lid." Client #2's mealtime protocol, dated December 14, 2007, and annual plan indicated the use of a Teflon-coated spoon. Neither client, however, was observed using those items during breakfast, afternoon break or dinner observations on March 10, 2008.	W 249		
252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria	W 252		

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W 252	Continued From page 20 specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure data relative to the accomplishment of the criteria specified in each client's Individual Program Plan (IPP) objective was documented in measurable terms, for two of the three clients in the sample. (Clients #1 and #2) The findings include: 1. Program data that staff were documenting for Client #1's self-feeding training program did not accurately reflect his performance/ ability, as follows: Cross-refer to W249.1 On March 10, 2008, observations at breakfast, afternoon snack and dinner revealed Client #1 received hand over hand assistance from staff. Together, they scooped pureed food on a built-up handled spoon and then raised the spoon to his mouth. After the client removed the food from his mouth, they lowered the spoon and allowed the client time to swallow. No further assistance or prompting was observed until they obtained the next spoonful of food. On March 12, 2008, at 12:25 PM, review of the client's IPP revealed the following: "With independence, <client's name> will use a spoon to feed himself during breakfast and dinner on 50 % of trials..." Subsequent review of the data collection sheets revealed that staff were documenting that he required physical prompts	W 252	W 252 1. This program has been discontinued and the staff will follow the mealtime protocol. 2. This program has been discontinued by the IDT. 3 and 4.cross refer to W 159-4 In the future the QMRP will ensure that the staff will complete daily progress notes on the clients. See attached – copy of shift reports	4/10/08

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252	Continued From page 21 for every step outlined in the task analysis, including swallowing the food. 2. The facility failed to collect data or otherwise document implementation of Client #1's restroom skills training program, as follows: Cross-refer to W249.2. On March 12, 2008, at 11:40 AM, review of Client #1's IPP, dated August 31, 2007, revealed the following: "...will open and close the restroom door and display appropriate restroom behaviors daily 25% of the total opportunities provided for 3 consecutive months..." This was not observed being implemented when the client used the restroom during the survey. Beginning at approximately 12:25 PM, review of the client's program book revealed no evidence that data collection sheets had been established for this program. Further review revealed that QMRP Monthly Progress Notes, dated 9/7/07, 10/6/07, 11/7/07, 12/8/07, 1/4/08 and 2/7/08, failed to report on the status of this training objective. 3. Facility staff failed to maintain accurate data regarding community outings/activities, which were included in Clients #1 and #2's IPPs, as follows: a. Cross-refer to W249.4 and W249.5. Review of Client #1's IPP on March 12, 2008 and Client #2's IPP on March 13, 2008 revealed that they both included team recommendations for community outings/ activities of choice. The former Qualified Mental Retardation Professional (QMRP) developed Activity Schedules for Clients #1 and #2, dated September 7, 2007 and January 4, 2008, respectively, for inclusion in the IPPs. The schedules prescribed Saturday and Sunday	W 252		

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252	Continued From page 22 outings. Review of their Community Outings documentation failed to show evidence that staff had facilitated weekend outings in accordance with their plans. There was, however, some evidence that staff had not documented all outings on the Community Outings data sheet as required. For example, on March 13, 2008, at approximately 2:38 PM, a Daily Note netered on the evening shift on March 1, 2008 indicated that Client #2 had gone on an "outing to video store." This had not been documented on her Community Outings sheet. b. Some entries made on Client #2's Community Outings data sheets had been altered and/or could not be verified. On March 13, 2008, beginning at 10:35 AM, review of the Community Outings data sheets revealed several dates listed for community outings since January 1, 2008 that had been visibly altered and/or did not match with known schedules. For example, staff had documented "went for community outing" from 12:00 PM - 3:05 PM on what had been 2/24. The date, however, was altered (different pen/ ink), with the 2 changed to a 1; it now read 1/24. Whereas February 24 was a Saturday, a mid-day outing on January 24, a Thursday, was unlikely. Other irregularities included outings to the Chateau nightclub listed for January 28 (a Monday), February 29 (a Friday) and March 1 (a Saturday). At 10:47 AM, interview with the House Manager confirmed that the clients attended the Chateau on Thursday evenings only, when the club sponsors a special night for persons with MR/DD. Other entries on the page were similarly suspect. [Note: The individual who made the alterations did not sign or put their initials.] c. Client #2's Daily Notes could not be used to	W 252		

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W 252	Continued From page 23 verify alleged community outings. On March 13, 2008, beginning at 2:24 PM, review of the client's Daily Notes revealed that on February 8, 2008, direct support staff documented that she was "home from day program had her snack and is resting in her room." The client's Community Outings sheet, however, had indicated a "walk to subway" that evening. Similarly, staff documented on Client #2's Saturday, March 1, 2008 Daily Notes that she had "bought a nice dress" from a store. The Community Outings sheet, however, indicated that she had been to the Chateau nightclub (with no mention of shopping). It should be noted that there were significant gaps in Client #2's Daily Notes documentation. On March 13, 2008, at 2:36 PM, the QMRP stated that it was the facility's policy that staff on each shift were expected to complete a Daily Note. Upon reviewing Client #2's Daily Notes, the QMRP acknowledged that staff had not consistently entered Daily Notes. For example, the Daily Notes skipped from February 25, 2008 to March 1, 2008 and then to March 7, 2008 (at which time someone wrote "4PM-12A shift" and nothing else to indicate what had happened with the client during that shift).	W 252		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients were provided with prescribed adaptive	W 322		

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	09G169	A. BUILDING _____ B. WING _____	03/13/2008

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322	Continued From page 24 equipment, such as straw lids on beverage glasses and/or Teflon coated spoons, to ensure their safety and health maintenance, for two of the two sampled clients who were prescribed adaptive equipment. (Clients #1 and #2) The findings include: Cross-refer to W436. The facility failed to ensure that Client #1 used a tumbler cup with lid and straw when drinking beverages, in accordance with his mealtime protocol, dated November 10, 2007. At both meals observed on March 10, 2008, he drank from a regular beverage tumbler, with no lid or straw. Similarly, Client #2 was not observed using a Teflon-coated spoon during breakfast and dinner on March 10, 2008. .The client's mealtime protocol, dated December 14, 2007, prescribed the use of a Teflon-coated spoon. On March 12, 2008, interviews with the Qualfield Mental Retardation Professional and the LPN Coordinator confirmed that the clients had not been using the adaptive meal equipment, as prescibed in their plans. There was no evidence that the medical team had monitored the continued use of appropriate adaptive mealtime equipment.	W 322	W 322 Teflon coated spoons and and a tumbler with a straw lid were obtained and one set has been delivered to the day program. In the future the facility will ensure adaptive equipment is used as ordered and day program has the equipment. See attached in service on adaptive equipment for program and residential sites. Receipt for adaptive equipment from the day program.	4/8/08
356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility	W 356		

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356	Continued From page 25 failed to ensure that clients received dental services in a timely manner, for two of the three clients in the sample. (Clients #1 and #2) The findings include: 1. On March 13, 2008, at 4:17 PM, review of Client #2's dental record revealed that she received a dental assessment on September 12, 2007. The dentist documented "heavy staining moderate calculus deposits" and recommended "patient needs scaling... will submit pre-authorization to Medicaid..." The client's record did not reflect a return visit. At 4:20 PM, interview with the recently-hired Qualified Mental Retardation Professional revealed that the client had an appointment scheduled for March 19, 2008, which was more than 6 months after treatment was prescribed. 2. On March 13, 2008, at 4:21 PM, review of Client #1's dental record revealed that on September 17, 2007, the dentist found "plaque and calculus present on all teeth surfaces" and recommended "full mouth scaling... will submit pre-authorization to Medicaid..." The client returned to the dentist on January 8, 2008, at which time he received treatment and the dentist recommended "brush teeth after each meal and before bedtime." There was no evidence, however, that the client received daily dental care in accordance with the dentist's recommendation, as follows: a. Client #1 was not observed to brush his teeth after breakfast (or before departure for day program) on March 10, 2008. On March 13, 2008, at 5:04 PM, interview with the RN revealed that staff had been instructed previously to assist	W 356	W 356 1.The dentist does cleaning every 6mths but needs authorization for deep scaling. He has completed this and his dental consult is attached. 2. a,b and c – client has a new tooth brushing program. The day program has been given toothpaste and a toothbrush. The HMCP has been updated accordingly. The QMRP and nurse will ensure there is close monitoring of staff performing this program The QMRP and nurse will also visit the day program at least monthly. See attached – tooth brushing program and data sheet, HMCP, recent dental consult and staff in service record	4/10/08

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356	Continued From page 26 him with tooth brushing every morning before departure for day program. b. At approximately 4:25 PM, review of Client #1's most recent Health Risk Management Care Plan (HRMCP), dated December 24, 2007, revealed that the client had been diagnosed previously (August 28, 2006) with periodontitis. The HRMCP instructed staff to "brush teeth 2-3 times a day." At 5:04 PM, the RN acknowledged that the HRMCP had not been updated to reflect more frequent (after every meal and at bedtime) daily dental care. c. During a March 10, 2008 visit to Client #1's day program, interviews with staff and review of the client's record revealed no indication that he brushed his teeth after lunch. On March 13, 2008, at 5:04 PM, the RN acknowledged that to date, the day program had not been asked to provide the client with tooth brushing assistance. Tooth brushing had been addressed in the home only.	W 356		
436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients were provided with and taught to use their adaptive equipment, such as straw lids on	W 436		

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V 436	Continued From page 27 beverage glasses and/or Teflon coated spoons, for two of the two sampled clients who were prescribed adaptive equipment. (Clients #1 and #2) The findings include: 1. The facility failed to ensure that Client #1 used a tumbler cup with lid and straw when drinking beverages, as follows: On March 10, 2008, Client #1 was observed at the breakfast table, beginning at approximately 7:06 AM. He used a built-up handled spoon and a high-sided divided plate. During the Entrance Conference, at approximately 8:45 AM, the Qualified Mental Retardation Professional (QMRP) and LPN Coordinator listed the same two items as Client #1's mealtime adaptive equipment. He used a built-up handled spoon and a high-sided divided plate at dinner that evening. On March 10, 2008, beginning at 3:30 PM, review of Client #1's medical chart revealed the following: A November 29, 2007 swallow study "Referral Request" form included: "patient presented no signs of symptoms of aspiration. There was no penetration or aspiration noted during the study. Patient recommended to continued puree diet and thin liquid." A December 14, 2007 Nutrition review reflected the swallow study findings. The Nutritionist recommended "continue double portions, pureed diet as ordered... staff to follow mealtime protocol..." At the dinner table that evening, March 10, 2008, at 5:55 PM, review of Client #1's mealtime	W 436	W 436 The mealtime protocol and POS have been corrected to show the adaptive equipment the client uses. In the future the facility will ensure that the documentation of adaptive equipment is accurate and consistent in all records. A monthly QA will be completed by the QMRP. See attached Mealtime protocol, POS and QA record.	4/12/08

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/ 436	Continued From page 28 protocol, dated 11/10/07, revealed that in addition to the built-up handled spoon and high sided divided plate, he was to use a lid with a straw on his beverage cup. At both meals observed that day, he drank from a regular beverage tumbler, with no lid or straw. This was the first indication that he should use a lid with straw. On March 11, 2008, beginning at 9:03 AM, review of Client #1's QMRP Monthly Progress Notes, dated 9/7/07, 10/6/07, 11/7/07, 12/8/07, 1/4/08 and 2/7/08, revealed that past and current QMRP's documented the client used a divided, high-sided plate and a cup with straw lid. On March 12, 2008, beginning at 10:12 AM, review of Client #1's Individual Support Plan (ISP), dated September 7, 2007, revealed inconsistent documentation of the adaptive equipment prescribed. In one section, the ISP listed "high sided plate and cup/tumbler with straw lid" (only), yet a few pages later, the ISP included a list of adaptive equipment, as follows: "high sided plate, built-up handle spoon, tumbler cup with straw lid, and Ted hose," all 4 of which were to be used "as needed." [Note: Interviews with nursing staff and review of Client #1's records did not reflect the use of Teds. One of his peers, however, had been prescribed Teds prior to her December 2007 hospitalization and subsequent discharge from the facility.] On March 12, 2008, continued review of Client #1's record revealed that he received an updated Occupational Therapy evaluation on September 25, 2007, 18 days after his interdisciplinary team met for his annual ISP review. The OT recommended the continued use of "the built-up handled spoon, high-sided sectioned plate and tumbler cup with straw lid." [Note: The same OT assessment indicated that the client used "custom molded shoe orthotic due to Pes	W 436		

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' 436	Continued From page 29 Planus." However,, the client had worn regular sneakers during the March 10, 2008 observations. Interviews with nursing staff and review of Client #1's records confirmed that custom molded shoes had not been prescribed for him.] It should be noted that review of staff in-service training records revealed that on March 4, 2008, the LPN Coordinator trained the QMRP and 5 direct support staff on the clients' adaptive equipment needs. The attached list included "high-sided divided plate and built-up handled spoon" for Client #1. The list did not reflect the use of a tumbler cup with straw lid. 2. The facility failed to ensure that Client #2 used a Teflon-coated teaspoon while eating, as follows: On March 10, 2008, beginning at approximately 7:06 AM, Client #2 was observed eating breakfast using a blue plastic spoon with a built-up handle, a high sided divided plate and a spout cup. She used the same adaptive equipment that evening at dinner. On March 11, 2008, a visit to the client's day program revealed that she had a mealtime protocol, dated December 14, 2007, that listed a Teflon-coated spoon (with no mention of a built-up handle). On March 11, 2008, at approximately 5:45 PM, the QMRP and LPN Coordinator were asked what spoon Client #2 should be using. The LPN Coordinator opened the client's chart, referred to the December 14, 2007 mealtime protocol and confirmed that she was to use a Teflon-coated teaspoon. The QMRP stated that there were Teflon-coated teaspoons in the storage closet in the basement. At 6:02 PM, inspection of the	W 436	W 436 The mealtime protocol and POS have been corrected to show the adaptive equipment the client uses. In the future the facility will ensure that the documentation of adaptive equipment is accurate and consistent in all records. A monthly QA will be completed by the QMRP. See attached Mealtime protocol, POS and QA record.	4/12/08

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' 436	Continued From page 30 kitchen revealed no evidence that Teflon-coated teaspoons had been available for the client's use prior to this survey. It should be noted that review of staff in-service training records revealed that on March 4, 2008, the LPN Coordinator trained the QMRP and 5 direct support staff on the clients' adaptive equipment needs. The attached list included "plastic coated teaspoon" for Client #2.	W 436		
V 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each shift conducted a fire drill four times a year. The findings include: On March 10, 2007, interview with the Qualified Mental Retardation Professional and review of the weekly staffing schedule indicated that on Monday-Friday there were primarily three designated shifts (8:00 AM - 12:00 PM; 4:00 PM - 12:00 AM; and 12:00 AM - 8:00 AM) and on Saturday and Sunday, there were primarily two designated shifts (8:00 AM - 12:00 midnight and 12:00 midnight - 8:00 AM). There was no evidence that the facility conducted simulated fire drills at least four times for each shift during the previous 12 months. On March 11, 2008, at 3:25 PM, review of the facility's documentation revealed that during the first quarter (March 2007 - May 2007), fire drills had	W 440	W 440 The facility has revised the Fire Drill schedule to include weekend shifts. All staff has been in serviced on the Fire and Safety Policy. See attached Fire drill schedule and in service record	4/10/08

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W 440	Continued From page 31 been conducted only on Sundays. Further review revealed no evidence that any drills were conducted on the weekday evening shift during the 2nd quarter (June 2007 - August 2007).	W 440		

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R 000	INITIAL COMMENTS A licensure survey was conducted from March 10, 2008 through March 13, 2008. A random sample of three residents was selected from a resident population of two men and three women with various degrees of disabilities. The findings of this survey were based on observations at the group home and at two day programs, interviews with residents, day program and residential staff as well as the review of clinical and administrative records, including incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of personnel records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check. The findings include: Review of the personnel files on March 12, 2008, beginning at 2:50 PM, revealed no evidence of comprehensive criminal background checks for the recently-hired Qualified Mental Retardation Professional (QMRP) and House Manager, and 2 of the 9 direct support staff, as follows: QMRP - A MD check was documented; however,	R 125	R 125 The Agency has a policy on employee background checks to be completed prior to the hiring process. In the future personnel records will be kept and updated accordingly at the facility. The QMRP will complete monthly QA which includes a review of personnel records. See attached background checks for #4 employees.	4/14/08

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R 125	Continued From page 1 he lived and worked in California between September 2001 - December 2006. House Manager - A DC check was documented; however, he lived in Maryland. S1 - Maryland and DC checks were documented; however, she had worked in PA just prior to her December 10, 2007 date of hire. S2 - A DC check was documented; however, she lived in Maryland.	R 125		

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I 000	INITIAL COMMENTS A licensure survey was conducted from March 10, 2008 through March 13, 2008. A random sample of three residents was selected from a resident population of two men and three women with various degrees of disabilities. The findings of this survey were based on observations at the group home and at two day programs, interviews with residents, day program and residential staff as well as the review of clinical and administrative records, including incident reports.	I 000		
I 002	3500.2 GENERAL PROVISIONS Each GHMRP licensee and residence director shall demonstrate that he or she understands that the provisions of D.C: Law 2-137, D.C. Code, Title 6, Chapter 19 govern the care and rights of mentally retarded persons in addition to this chapter. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP licensee and residence director failed to demonstrate that he or she understood that the provisions of Title 7, Capter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) govern the care and rights of mentally retarded persons. The findings include: I. The facility failed to demonstrate protection of residents' rights to receive habilitation, care or both in accordance with their Individual Support Plans (ISPs) [Title 7, Chapter 13, § 7-1305.04(c), formerly § 6-1964(c)], as follows:	I 002		

Regulation Administration

Swant. Sloan RN BSN MA — VP-Operations — 4/10/08

ATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

E FORM 6899 1NGO11 If continuation sheet 1 of 25

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I 002	Continued From page 1 A. Cross-refer to federal deficiency report - Citation W436. Resident #1's mealtime protocol, dated November 11, 2007, and annual plan indicated the use of a "tumbler cup with straw lid." Simialrly, Resident #2's mealtime protocol, dated December 14, 2007, and annual plan indicated the use of a Teflon-coated spoon. Neither resident, however, was observed using those items during breakfast, afternoon break or dinner observations on March 10, 2008. B. Cross-refer to I422.1. Resident #1's mealtime protocol and self-feeding training program were not implemented as written. C. Cross-refer to I422.2. The GHMRP failed to implement Resident #1's privacy skills training program, in accordance with his interdisciplinary team recommendation. D. Cross-refer to I422.3 GHMRP staff failed to consistently implement Resident #1's napkin-use training program. E. Cross-refer to I019, I422.4 and I422.5. The GHMRP failed to ensure the provision of transportation or otherwise facilitate attendance to church and other preferred community activities, in accordance with resident ISPs. F. The facility failed to ensure that Residents #1 and #2 received dental services in a timely manner, as follows: 1) On March 13, 2008, at 4:17 PM, review of Resident #2's dental record revealed that she received a dental assessment on September 12, 2007. The dentist documented "heavy staining moderate calculus deposits" and recommended "patient needs scaling... will submit	I 002	I 002 A. cross refer W 436 B. cross refer W I 422.1 C. cross refer W I 422.2 D. cross refer W 422.3 E. cross refer W 422.4 and W 422.5 F.1. cross refer W 356 F.2a,b and c. cross refer W 356 F.II. cross refer I 401	

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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I 002	Continued From page 2 pre-authorization to Medicaid..." The resident's record did not reflect a return visit. At 4:20 PM, interview with the recently-hired Qualified Mental Retardation Professional revealed that the resident had an appointment scheduled for March 19, 2008, which was more than 6 months after treatment was prescribed. 2) On March 13, 2008, at 4:21 PM, review of Resident #1's dental record revealed that on September 17, 2007, the dentist found "plaque and calculus present on all teeth surfaces" and recommended "full mouth scaling... will submit pre-authorization to Medicaid..." The resident returned to the dentist on January 8, 2008, at which time he received treatment and the dentist recommended "brush teeth after each meal and before bedtime." There was no evidence, however, that the resident received daily dental care in accordance with the dentist's recommendation, as follows: (a) Resident #1 was not observed to brush his teeth after breakfast (or before departure for day program) on March 10, 2008. On March 13, 2008, at 5:04 PM, interview with the RN revealed that staff had been instructed previously to assist him with tooth brushing every morning before departure for day program. (b) At approximately 4:25 PM, review of Resident #1's most recent Health Risk Management Care Plan (HRMCP), dated December 24, 2007, revealed that the resident had been diagnosed previously (August 28, 2006) with periodontitis. The HRMCP instructed staff to "brush teeth 2-3 times a day." At 5:04 PM, the RN acknowledged that the HRMCP had not been updated to reflect more frequent (after every meal and at bedtime) daily dental care.	I 002		

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002	Continued From page 3 (c) During a March 10, 2008 visit to Resident #1's day program, interviews with staff and review of the resident's record revealed no indication that he brushed his teeth after lunch. On March 13, 2008, at 5:04 PM, the RN acknowledged that to date, the day program had not been asked to provide the resident with tooth brushing assistance. Tooth brushing had been addressed in the home only. II. The facility failed to demonstrate demonstrate protection of residents' rights to receive a comprehensive psychological re-evaluation [Title 7, Chapter 13, § 7-1305.04(a), formerly § 6-1964(a)], as follows: Cross-refer to I401. The GHMRP failed to ensure that Resident #1's psychologist assessed his behavior of sucking on shirt sleeves and/or collar and re-assessed his toileting skills after failing to achieve performance criteria on a previous toilet training program.	I 002		
I 019	3501.3(h) ENVIRONMENTAL REQ / USE OF SPACE 3501.3 Each GHMRP shall be within easy walking distance of public transportation or demonstrate that it can provide transportation for its residents to the following facilities: (h) Churches; and... This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure the provision of transportation or otherwise facilitate attendance to church (and other preferred community activities), for two of the three residents in the sample. (Residents #1	I 019	I 019 1. cross refer W 136	

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I 019	Continued From page 4 and #2) The findings include: 1. On March 12, 2008, at approximately 10:28 AM, review of Resident #1's Individual Support Plan (ISP), dated September 6, 2007, revealed a list of preferred activities which included "go on outings... going to church." At 12:02 PM, review of Resident #1's Activity Schedule that was incorporated in his ISP, revealed that on Saturdays, he was to go out in the community, beginning at 11:00 AM. On Sundays, the resident was scheduled to attend church at 10:00 AM and engage in another community activity, beginning at 3:00 PM. On March 13, 2008, beginning at 10:27 AM, review of Resident #1's Community Outings documentation chart for the period October 2007 to date revealed the following: - There was no evidence that he went to church in October 2007, November 2007, February 2008 or thus far in March 2008; - The October 2007 outings sheet reflected one Thursday evening outing (nightclub, October 4, 2007) and one Sunday trip to a shopping mall (October 7, 2007); - There were two outings documented in January 2008: church on Tuesday, January 8, 2008 and a "national monument" on Saturday, January 12, 2008; - The three outings documented in February 2008 were on weekday evenings; none were on weekends; and,	I 019		

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I 019	Continued From page 5 - there were no documented outings thus far in March 2008. 2. Similarly, the facility failed to ensure that Resident #2 participated in community outings/ recreational activities in accordance with her Activity Schedule, as follows: On March 13, 2008, at 12:01 PM review of Resident #2's Activity Schedule that was incorporated in her January 4, 2008 annual ISP, revealed that on Saturdays, she was to go out in the community, between 2:00 PM - 5:00 PM. On Sundays, the resident was scheduled to attend church at 10:00 AM and later, engage in another community activity, from 2:00 PM - 5:00 PM. A subsequent review of Resident #2's Community Outings documentation chart for the period January 1, 2008 to date revealed no evidence that she went on community outings on Saturdays and Sundays, including church services, in accordance with her plan.	I 019		
I 071	3503.2 BEDROOMS AND BATHROOMS Each bed shall be placed at least three feet (3 ft.) from any other bed and at least three feet (3 ft.) from any unprotected radiator. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that two residents' beds were at least 36 inches apart. (Residents #2 and #4) The finding includes: On March 13, 2008, at 7:05 PM, Resident #2's bed was observed placed only 21 inches away	I 071	I 071 Clients' beds were separated to make sure there was at least 3 feet space between them.	4/8/08

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I 071	Continued From page 6 from Resident #4's bed. The Qualified Mental Retardation Professional acknowledged that the beds were less than 36 inches apart.	I 071		
I 082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure that bathrooms were equipped with paper cups. The finding includes: On March 13, 2008, at 6:52 PM, the paper cup dispenser located in the main bathroom (in the center hallway) was empty.	I 082	I 082 The QMRP has in serviced all the staff in House keeping procedures and the paper cups for the clients' use is being replenished as needed. In the future the House Manager will make sure that the environmental needs for the clients are met by making daily environmental inspections.	4/8/08.
I 097	3504.8 HOUSEKEEPING No cleaning agent, bleach, insecticide or any other poisonous, dangerous, or flammable material shall be accessible to a resident where access to such substance is contraindicated in the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure that cleaning agents were not accessible to the residents. The finding includes:	I 097	I 097 Container of Comet was removed immediately. Staff was in serviced on Housekeeping procedures. See attached in service record	

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I 097	Continued From page 7 On March 13, 2008, at 6:52 PM, an open canister of powdered Comet cleanser with bleach was observed in the vanity cabinet beneath the hand sink in the main bathroom located in the center hallway.	I 097		
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each shift conducted a fire drill four times a year. The findings include: On March 10, 2007, interview with the Qualified Mental Retardation Professional and review of the weekly staffing schedule indicated that on Monday-Friday there were primarily three designated shifts (8:00 AM - 12:00 PM; 4:00 PM - 12:00 AM; and 12:00 AM - 8:00 AM) and on Saturday and Sunday, there were primarily two designated shifts (8:00 AM - 12:00 midnight and 12:00 midnight - 8:00 AM). There was no evidence that the facility conducted simulated fire drills at least four times for each shift during the previous 12 months. On March 11, 2008, at 3:25 PM, review of the facility's documentation revealed that during the first quarter (March 2007 - May 2007), fire drills had been conducted only on Sundays. Further review revealed no evidence that any drills were conducted on the weekday evening shift during the 2nd quarter (June 2007 - August 2007).	I 135	I 135 Cross refer W 440	

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206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff obtained annual health certificates/ inventories. The findings include: Review of the personnel records on March 12, 2008, beginning at 2:50 PM, revealed the following: 1. The most recent health certificate/ inventory on file for 1 of the 9 direct support staff (S3) was dated March 31, 2006, almost 2 years earlier. 2. The most recent health certificate/ inventory on file for one Trained Medication Employee (TME) was dated January 22, 2007, and therefore, had expired. [Note: On March 18, 2008, the facility submitted via fax transmittal, an updated health certificate for the TME. The document indicated that the physical examination was performed on March 17, 2008, four days after the survey ended.] This is a repeat deficiency. See State licensure deficiency report dated 3/9/07.	I 206	I 206 1. See attached health certificate for staff S3 In the future the facility will ensure that all personnel records are kept current. This process will be overseen by the QMRP on a monthly QA system.	4/10/08

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I 227	Continued From page 9	I 227		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on interview and review of personnel records made available, the GHMRP failed to ensure that all staff had received training in first aid and certification in Cardiopulmonary resuscitation (CPR), in accordance with agency policies. The findings include: On March 12, 2008, beginning at 2:50 PM, review of personnel files and staff in-service training records revealed the following: 1. There was no documented evidence of first aid training within the previous 3 years for 4 of the 9 direct support staff (S1, S2, S3 and S4). 2. There was no documented evidence of CPR certification for 3 of the 9 direct support staff (S1, S2 and S3).	I 227	I 227 See attached first aid training for S1,S2,S3 and S4 and CPR for S1,S2 and S3. In the future the facility will ensure that all personnel records are kept current. This process will be overseen by the QMRP on a monthly QA system.	4/14/08
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;	I 229		

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I 229	Continued From page 10 This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to train all staff on specialty areas such as recreation and total communication. The findings include: On March 13, 2007, review of the staff in-service training records and interview with the recently-hired Qualified Mental Retardation Professional revealed no evidence that the GHMRP trained its direct support staff on the following topics: - recreation, and - communication It should be noted that review of documentation for Resident #1's and #2's community outings failed to show evidence that the residents experienced preferred community outings/ recreational activities at the frequency prescribed in their ISP Activity Schedules. (See I019)	I 229	I 229 The QMRP and House Manager will ensure that the recreation calendar is followed and the clients have the opportunity to go out. The staff has been re in serviced in accurate documentation of all outings. See attached in service training record for recreation and activity schedules.	4/10/08
I 274	3513.1(e) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (e) Signed agreements or contracts for professional services; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of a signed agreement or contract with each consultant providing professional services.	I 274	I 274 See attached psychiatrist's contract. In the future the HR Dept. will ensure the consultant staff signs all contracts before they are hired.	4/10/08

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I 274	Continued From page 11 The finding includes: Interview with the Qualified Mental Retardation Professional and review of personnel records on March 12, 2008 revealed that the GHMRP failed to have a contract or written agreement on file for the consulting psychiatrist.	I 274		
I 371	3519.2 EMERGENCIES Each GHMRP shall maintain written documentation that each employee has been trained in carrying out the policies and procedures set forth in § 3519.1 of this section. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to train all staff on the agency's emergency policies and procedures (fire evacuations, disasters, etc.). The finding includes: On March 13, 2007, review of the staff in-service training records and interview with the recently-hired Qualified Mental Retardation Professional revealed no evidence that the GHMRP trained its direct support staff on the agency's emergency policies and procedures.	I 371	I 371 In the future the facility will ensure that all training records are kept current. This process will be overseen by the QMRP on a monthly QA system. See attached in service record on emergency policies and procedures.	4/10/08
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.	I 401		

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I 401	Continued From page 12 This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure psychological services (i.e. assessment), in accordance with the needs of one of the three residents in the sample. (Resident #1) The finding includes: 1. On March 10, 2008, Resident #1 was observed in the home between 7:06 AM - 7:33 AM. His shirt collar was notably wet throughout the period. On several occasions, the resident placed his shirt collar in his mouth and held it there for several minutes. At 7:33 AM, the House Manager assisted him with changing into a different shirt, before leaving for day program. Resident #1 was observed in his day program between 12:27 PM - 12:50 PM. The ends of both shirt sleeves and his collar were wet upon this surveyor's arrival. The resident repeatedly put his shirt sleeves into his mouth. Day program staff confirmed that he routinely placed his shirt in his mouth. At 12:38 PM, the staff rolled the resident's shirt sleeves up and commenced to play ball toss. At least three times between 12:38 PM - 12:48 PM, the resident rolled the sleeves back down and staff asked him to keep them sleeves rolled up. He kept his left thumb buried inside his left shirt sleeve, and mouthed it occasionally. At 12:31 PM, another staff person assisted the resident with changing into a fresh shirt (red) and pants. The staff who had engaged him in ball toss stated that even though he did it daily, mouthing his clothes was not among the behaviors targeted in his Behavior Support Plan (BSP).	I 401		

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I 401	Continued From page 13 Evening observations of Resident #1 resumed upon his return home. At 4:28 PM, Resident #1 was seated at the dining room table eating snack. The collar and both sleeves of the red shirt (worn since the change at day program) were notably wet. At 5:58 PM, Resident #1 was observed mouthing his shirt collar. He remained in the wet shirt until at least 6:41 PM (possibly longer). On March 11, 2008, at 5:25 PM, the Qualified Mental Retardation Professional stated that the psychologist was scheduled to come to the facility the next week to assess the resident's shirt-mouthing behavior and to provide appropriate recommendations. On March 12, 2008, beginning at 9:20 AM, review of Resident #1's Psychological Assessment, dated August 30, 2007, revealed the following: "...also suck his fingers, engage in hand to mouth self-stimulation behaviors, bite finger nails sometimes..." There was no evidence, however, that the psychologist had assessed his behavior of sucking on shirt sleeves and/or collar. 2. The facility failed to re-assess Client #1's toileting skills: During the March 10, 2008 Entrance Conference, it was stated that Resident #1 used adult protective undergarments (APUs) due to fecal and urinary incontinence. On March 12, 2008, at 9:32 AM, review of the resident's Annual Psychological Assessment, dated August 30, 2007, revealed the following: "... is not toilet trained but he will sometimes urinate and defecate in toilet when assisted." The psychologist provided no further information or recommendations regarding toileting skills. Review of Resident #1's September 7, 2007 Individual Support Plan (ISP), at 10:16 AM,	I 401		

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I 401	Continued From page 14 revealed the following: "... uses adult attends continues to be on a program to improve his toileting skills." At 11:40 AM, however, review of his IPP, dated August 31, 2007, revealed no training objective that dealt directly with his toileting needs. On March 12, 2008, at approximately 12:18 PM, the recently-hired QMRP was asked about Resident #1's toileting program. He reported that Resident #1 was without a set toileting schedule. Staff relied on the use of APUs because the resident often refused to use the toilet. The interview revealed that there were behavioral considerations that to date, had not been fully assessed. According to the QMRP, the resident generally would agree to sit on the toilet if staff loosened his belt, made a request and then stepped back. However, if staff removed the belt and lowered his pants for him, the resident would resist. If staff continued to insist, then he would refuse to cooperate. While there was no toileting schedule prescribed, staff reportedly checked his APU upon return from day program and periodically thereafter, and changed him if/when wet. QMRP Monthly Progress Notes, dated 9/7/07, 10/6/07, 11/7/07, 12/8/07, 1/4/08 and 2/7/08, had reported on the following goal: "Three times weekly with staff assistance, <resident's name> will complete the steps to proper toilet use with 80% accuracy..." Further review revealed that the QMRP had written the following statement in each monthly report, beginning at least as far back as February 6, 2007: "He performed Step 1 with verbal prompt, Steps 2-7 with physical prompts. He has reach his highest level of performance. Program discontinued and continue on an informal basis."	I 401	I 401 1. The psychologist has re assessed the client and has a BSP for the shirt mouthing behavior. 2. This program has been discontinued, as the client is unable to comprehend his toileting needs. He is functioning at a 9mth cognitive level and a 1yr 9mth adaptive level. Staff continues to follow 2hr APU checks. The psychologist has included the toileting status in his re assessment. In the future the QMRP will ensure that a monthly QA is completed to encompass a review of all assessments and programming needs.	4/10/08

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I 401	Continued From page 15 While Resident #1's September 7, 2007 ISP indicated that he"... uses adult attends continues to be on a program to improve his toileting skills," there was no evidence that the interdisciplinary team had reviewed the resident's progress or lack thereof, discussed the former QMRP's recommendation (since February 2007) to discontinue the formal training program, and agreed that a toileting schedule would not be appropriate for Resident #1.	I 401		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the provision of habilitation and training as outlined in the Individual Program Plans (IPPs), for three of the three residents in the sample. (Residents #1, #2, and #3) The findings include: 1. Resident #1's mealtime protocol and self-feeding training program were not implemented as written, as follows: On March 10, 2008, beginning at approximately 7:10 AM, a direct support staff person was observed providing Resident #1 with hand over hand assistance while eating breakfast. Together, they loaded food onto the spoon and together, they raised the spoon to the resident's mouth. At approximately 4:30 PM that evening, direct support staff was observed providing the	I 422	I 422 1a and b. Cross refer to W 159 2. cross refer to W 159 3. cross refer to W 159 4. and 5. cross refer to W 159 6. cross refer to W 249 7. cross refer to W 159	

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I 422	Continued From page 16 same level of hand over hand assistance while eating a snack (pudding). And beginning at 6:02 PM, the recently-hired (2 weeks) House Manager was observed providing the same level of hand over hand assistance with the dinner meal. a. On March 11, 2008, at 10:23 AM, review of the resident's annual plan, dated September 7, 2007, revealed that the resident "requires partial hand over hand assistance with feeding." On March 12, 2008, at 12:25 PM, review of his IPP revealed the following: "With independence, <resident's name> will use a spoon to feed himself during breakfast and dinner on 50 % of trials..." Although the training objective did not provide clear instructions to staff on how to implement the program, review of the resident's OT assessment, dated September 25, 2008, revealed that he needed staff assistance to load food onto his spoon; however, he was capable of bringing the spoon to his mouth with minimal assistance. On March 13, 2008, at approximately 3:05 PM, review of Resident #1's mealtime protocol, dated November 10, 2007, revealed the following: "<resident's name> can bring the spoon from the plate to his mouth and remove food from the spoon but he does not initiate loading spoon with food." Observations on March 10, 2008, however, had shown that staff did not allow or encourage him to perform those tasks to his maximum abilities. Instead, they provided hand over hand assistance throughout the process, and documented on the data collection sheet that this was the level required. b. On March 10, 2008, at 4:45 PM, the medication nurse crushed Resident #1's medications and stirred them into apple sauce. At 4:56 PM, the nurse spoonfed the mixture into the resident's mouth, without offering him the	I 422		

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422	Continued From page 17 opportunity or encouragement to hold the spoon himself. At 5:30 PM, during a post-med pass conversation, the LPN indicated that she was aware that the resident received hand over hand assistance while eating food. After stating that the training program was to be implemented at meals, she acknowledged that she did not routinely provide the resident with an opportunity to practice using a spoon during his med pass. 2. The facility failed to implement Resident #1's privacy skills training program, as follows: During the March 10, 2008 Entrance Conference, it was stated that Resident #1 used adult protective undergarments (APUs) due to fecal and urinary incontinence. On March 12, 2008, at 11:40 AM, review of the resident's IPP, dated August 31, 2007, revealed the following: "...will open and close the restroom door and display appropriate restroom behaviors daily 25% of the total opportunities provided for 3 consecutive months..." This was not observed being implemented when the resident used the restroom during the survey. On March 12, 2008, beginning at approximately 12:25 PM, review of the resident's program book revealed no evidence that data collection sheets had been established for the "open/ close the bathroom door" program. 3. Facility staff failed to consistently implement Resident #1's napkin-use training program, as follows: On March 10, 2008, beginning at approximately 7:10 AM, Resident #1 was observed at breakfast. Later, at approximately 4:30 PM, he ate a snack (pudding). The resident was also observed at dinner that day, beginning at 6:02 PM. Direct	I 422		

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422	Continued From page 18 support staff and/or the recently-hired House Manager provided direct assistance to Resident #1 throughout the meals. Each time, staff was observed using a napkin to wipe his mouth periodically during the meal and after he finished eating. At no time were staff observed offering the resident his napkin, with instructions and/or encouragement to wipe his own mouth. On March 12, 2008, at 11:26 AM, review of his IPP, dated August 31, 2007, revealed the following: ".Given physical assistance, <resident's name> will use a napkin to wipe his mouth after meals on 80% of trials for 6 consecutive months..." Review of the QMRP Monthly Progress Notes, dated 9/7/07, 10/6/07, 11/7/07, 12/8/07, 1/4/08 and 2/7/08, revealed that staff had been recording the resident's napkin use. Observations on March 10, 2008, however, failed to show evidence that the program was being implemented consistently. 4. The facility failed to ensure that Resident #1 participated in community outings/ recreational activities in accordance with his Activity Schedule, as follows: On March 12, 2008, at approximately 10:28 AM, review of Resident #1's Individual Support Plan (ISP), dated September 6, 2007, revealed a list of preferred activities which included "go on outings... going to church." At 12:02 PM, review of Resident #1's Activity Schedule that was incorporated in his ISP, revealed that on Saturdays, he was to go out in the community, beginning at 11:00 AM. On Sundays, the resident was scheduled to attend church at 10:00 AM and engage in another community activity, beginning at 3:00 PM.	422		

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I 422	Continued From page 19 On March 13, 2008, beginning at 10:27 AM, review of Resident #1's Community Outings documentation chart for the period October 2007 to date revealed the following: - There was no evidence that he went to church in October 2007, November 2007, February 2008 or thus far in March 2008; - The October 2007 outings sheet reflected one Thursday evening outing (nightclub, October 4, 2007) and one Sunday trip to a shopping mall (October 7, 2007); - There were two outings documented in January 2008: church on Tuesday, January 8, 2008 and a "national monument" on Saturday, January 12, 2008; - The three outings documented in February 2008 were on weekday evenings; none were on weekends; and, - there were no documented outings thus far in March 2008. 5. Similarly, the facility failed to ensure that Resident #2 participated in community outings/ recreational activities in accordance with her Activity Schedule, as follows: On March 13, 2008, at 12:01 PM review of Resident #2's Activity Schedule that was incorporated in her January 4, 2008 annual plan, revealed that on Saturdays, she was to go out in the community, between 2:00 PM - 5:00 PM. On Sundays, the resident was scheduled to attend church at 10:00 AM and later, engage in another community activity, from 2:00 PM - 5:00 PM.	I 422		

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I 422	Continued From page 20 A subsequent review of Resident #2's Community Outings documentation chart for the period January 1, 2008 to date revealed no evidence that she went on community outings on Saturdays and Sundays, including church attendance, in accordance with her plan. 6. The facility nurse failed to implement Resident #3's self-medication training program, as follows: During the medication pass observation on March 10, 2008, at 4:52 PM, the nurse punched Resident #3's medication (Zyprexa) from its blister pack into a small medication cup. The resident brought her glass of water from the kitchen and when the nurse handed her the medication cup, she took the medication independently, followed by water. On March 11, 2008, at 2:06 PM, review of the resident's medical records revealed that the resident had a 7-task self-medication objective whereby she was to obtain a key to a medication box, open the box, read the medication label, obtain the medication, place the medication in the box, obtain her own water and then swallow the pills under supervision. It should be noted that the nurse documented on the data collection sheet that Resident #3 had obtained the key, opened the box and obtained the medication with verbal prompts on the previous evening (March 10, 2008), even though the resident had not been observed performing those tasks. 7. The facility failed to ensure that Residents #1 and #2 had available for use the adaptive equipment prescribed for mealtimes, as follows: Cross-refer to federal deficiency report - Citation	I 422		

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I 422	Continued From page 21 W436. Resident #1's mealtime protocol, dated November 11, 2007, and annual plan indicated the use of a "tumbler cup with straw lid." Resident #2's mealtime protocol, dated December 14, 2007, and annual plan indicated the use of a Teflon-coated spoon. Neither resident, however, was observed using those items during breakfast, afternoon break or dinner observations on March 10, 2008 and there was no evidence that the facility's medical team had monitored the use of prescribed adaptive mealtime equipment.	I 422		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Capter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) govern the care and rights of mentally retarded persons and other applicable laws. The findings include: 1. The facility failed to protect residents' rights to receive habilitation, care or both in accordance with their Individual Support Plans (ISPs) [Title 7, Chapter 13, § 7-1305.04(c), formerly § 6-1964(c)], as follows: A. Cross-refer to federal deficiency report -	I 500	I 500 1A. cross refer to W 436 B. cross refer to I 422.1 C. cross refer to I 422.2	

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I 500	Continued From page 22 Citation W436. Resident #1's mealtime protocol, dated November 11, 2007, and annual plan indicated the use of a "tumbler cup with straw lid." Resident #2's mealtime protocol, dated December 14, 2007, and annual plan indicated the use of a Teflon-coated spoon. Neither resident, however, was observed using those items during breakfast, afternoon break or dinner observations on March 10, 2008. B. Cross-refer to I422.1. Resident #1's mealtime protocol and self-feeding training program were not implemented as written. C. Cross-refer to I422.2. The GHMRP failed to implement Resident #1's restroom skills training program, in accordance with his interdisciplinary team recommendation. D. Cross-refer to I422.3 GHMRP staff failed to consistently implement Resident #1's napkin-use training program. E. Cross-refer to I019, I422.4 and I422.5. The GHMRP failed to ensure the provision of transportation or otherwise facilitate attendance to church and other preferred community activities, in accordance with resident ISPs. F. The facility failed to ensure that Residents #1 and #2 received dental services in a timely manner, as follows: 1) On March 13, 2008, at 4:17 PM, review of Resident #2's dental record revealed that she received a dental assessment on September 12, 2007. The dentist documented "heavy staining moderate calculus deposits" and recommended "patient needs scaling... will submit pre-authorization to Medicaid..." The resident's	I 500		

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I 500	Continued From page 23 record did not reflect a return visit. At 4:20 PM, interview with the recently-hired Qualified Mental Retardation Professional revealed that the resident had an appointment scheduled for March 19, 2008, which was more than 6 months after treatment was prescribed. 2) On March 13, 2008, at 4:21 PM, review of Resident #1's dental record revealed that on September 17, 2007, the dentist found "plaque and calculus present on all teeth surfaces" and recommended "full mouth scaling... will submit pre-authorization to Medicaid..." The resident returned to the dentist on January 8, 2008, at which time he received treatment and the dentist recommended "brush teeth after each meal and before bedtime." There was no evidence, however, that the resident received daily dental care in accordance with the dentist's recommendation, as follows: (a) Resident #1 was not observed to brush his teeth after breakfast (or before departure for day program) on March 10, 2008. On March 13, 2008, at 5:04 PM, interview with the RN revealed that staff had been instructed previously to assist him with tooth brushing every morning before departure for day program. (b) At approximately 4:25 PM, review of Resident #1's most recent Health Risk Management Care Plan (HRMCP), dated December 24, 2007, revealed that the resident had been diagnosed previously (August 28, 2006) with periodontitis. The HRMCP instructed staff to "brush teeth 2-3 times a day." At 5:04 PM, the RN acknowledged that the HRMCP had not been updated to reflect more frequent (after every meal and at bedtime) daily dental care.	I 500		

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I 500	Continued From page 24 (c) During a March 10, 2008 visit to Resident #1's day program, interviews with staff and review of the resident's record revealed no indication that he brushed his teeth after lunch. On March 13, 2008, at 5:04 PM, the RN acknowledged that to date, the day program had not been asked to provide the resident with tooth brushing assistance. Tooth brushing had been addressed in the home only. II. The facility failed to protect Resident #1's right to receive a comprehensive psychological re-evaluation [Title 7, Chapter 13, § 7-1305.04(a), formerly § 6-1964(a)], as follows: Cross-refer to I401. The GHMRP failed to ensure that Resident #1's psychologist assessed his behavior of sucking on shirt sleeves and/or collar and re-assessed his toileting skills and/or training needs after failing to progress on a previous toilet training objective.	I 500		